East End Endodontics
Financial Policy and Privacy Practices

Dear Patient:

Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. Here is an outline of our financial policy so that we may meet this goal.

● Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, and American Express. Outside financing is available through Care Credit upon approval.
● Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to the contract. Our financial relationship is with you, our patient, not your insurance company.
● All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. We will submit an insurance claim as a courtesy; however, this does not eliminate your financial obligation for your treatment. We cannot make any guarantee of any estimated coverage or payment.
● If payment is not received from your insurance company within 60 days from date of service, you will be expected to pay the balance in full. You will be responsible for seeking reimbursement from your insurance company at that time.
● We cannot guarantee that your insurance will pay for treatment received at our office. If your claim is denied, you are responsible for paying for the full amount.
● Returned checks and balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Also, since your bank must, by law, inform you of a returned check we will expect you to contact us to make arrangements for settling the full amount, plus a $25.00 fee within 10 (ten) days. If the matter is not settled by that time, late fees will be assessed.
● We require that you sign this form and /or any other necessary documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.
● Our office will not enter into a dispute with your insurance company. We will provide any required documentation, but it is your responsibility to resolve any dispute over payments made or not made by your insurance company. Your appointment is time that has been reserved especially for you. If you must change your appointment, we require at least 48 hours notice to avoid a **$75.00** no show fee. This will need to be paid before you will be seen again.

I hereby acknowledge that I read and received a copy of East End Endodontics Financial Policy and agree to its terms:

Patient Signature_____Date_____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);

Obtaining payment from third party payers (e.g. my insurance company);

The day-to-day healthcare operations of East End Endodontics.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent, is not affected.

Signature: _____

Print Name: _____

Relationship to Patient: _____
Date:_____/_____/_____